PRINTED: 05/02/2013
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0503	A. BUILDING: _____ B. WING _____	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION- FA	307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During annual Licensure survey and complaint survey #31201 conducted on April 22-25, 2013, at Kindred Health and Rehab Fairpark, no deficiencies were cited in relation to the complaint #31201 under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

Donna D. Hammontree
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director
TITLE

5/13/13
(X6) DATE